MDR Tracking Number: M5-04-3536-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution –General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 6-16-04.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that office visits, hot-cold packs, electrical stimulation, ultrasound, myofascial release, office visits with manipulation, chiropractic manual treatment-spinal, manual therapy techniques, acupuncture, supplies, telephone call by physician, special report and neuromuscular reeducation from 6-20-03 through 1-31-04 were not medically necessary. Therefore, the requestor is not entitled to a reimbursement of the paid IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were not the only fees involved in the medical dispute to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 9-8-04 the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

The carrier denied CPT Code 99080-73 with a V for unnecessary medical treatment based on a peer review, however, the TWCC-73 is a required report and is not subject to an IRO review. The Medical Review Division has jurisdiction in this matter and, therefore, recommends reimbursement. Requester submitted relevant information to support delivery of service. Per 134.1(c) **recommend reimbursement of CPT Code 99080-73 for dates of service from 11-1-03 through 1-3-04 for a total of $60.00.**

Pursuant to 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees from 11-1-03 through 1-3-04 as outlined above:

- in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (c);
- plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Decision and Order is hereby issued this 21st day of October 2004.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division

NOTICE OF INDEPENDENT REVIEW DECISION

September 3, 2004 **AMENDED LETTER 09/10/04**

Rosalinda Lopez
Program Administrator
Medical Review Division
Texas Workers Compensation Commission
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: Injured Worker:
MDR Tracking #: M5-04-3536-01
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care. TMF's health care professional has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to TMF for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This 65 year-old patient fell on ice at work on ___, hitting his head on the ground. His diagnosis is listed as closed head injury and post concussion syndrome. He continued to experience headaches, cloudy vision, balance problems, and neck pain. He has received extensive chiropractic treatment beginning on 03/19/03 and pain management.

Requested Service(s)

Office visits, hot/cold packs, electrical stimulation, ultrasound, myofascial release, office visits with manipulation, chiropractic manual treatment – spinal, manual therapy techniques, acupuncture, supplies and materials, telephone call by physician to patient, special report and neuromuscular reeducation for dates of service from 06/20/03 through 01/31/04.

Decision

It is determined that there is no medical necessity for the office visits, hot/cold packs, electrical stimulation, ultrasound, myofascial release, office visits with manipulation, chiropractic manual treatment – spinal, manual therapy techniques, acupuncture, supplies and materials, telephone call by physician to patient, special report and neuromuscular reeducation for dates of service from 06/20/03 through 01/31/04.

Rationale/Basis for Decision

Medical record documentation does not indicate the necessity for the office visits, hot/cold packs, electrical stimulation, ultrasound, myofascial release, office visits with manipulation, chiropractic manual treatment – spinal, manual therapy techniques, acupuncture, supplies and materials, telephone call by physician to patient, special report and neuromuscular reeducation. National treatment guidelines allow for chiropractic care and therapy for injuries of this nature however the guidelines do not allow for the intensity, frequency or number of chiropractic treatment this patient has received. The patient had an

extended trial of chiropractic care and therapy with no sufficient response to clinically justify on-going chiropractic care and therapy, therefore the treatments in questions were not medically necessary to treat this patient's medical condition.

Sincerely,